AHCCCS

# ENCOUNTER KEYS

Inside this issue:



## Change to Reimbursement Methodology for Freestanding Ambulatory Surgical Centers

As you know, the Centers for Medicare and Medicaid Services (CMS) issued a new payment system for Freestanding Ambulatory Surgical Centers (ASCs). Medicare adopted this payment system on January 1, 2008. AHCCCS will adopt a Medicare-like system for dates of service on and after October 1, 2008.

Here are some main highlights of the new AHCCCS ASC fee schedule:

1. **Rates**

As you know, AHCCCS has historically used an ASC Grouper system for pricing, which is no longer supported by CMS. Therefore the new AHCCCS ASC fee schedule will not group rates, but will assign a rate to each allowable code. This structure is very similar to the new Medicare ASC structure, but rates will be AHCCCS specific. Unlike Medicare's ASC fee schedule, AHCCCS will not bundle procedure codes with implants. The new ASC Fee Schedule rates are expected to be available mid to late July.

2. **Codes**

This change will also expand access to procedures in the ASC setting by providing payment for approximately 2,000 additional procedure codes formerly not eligible for billing in a Freestanding ASC. All of the allowable codes are expected to be available in the above-mentioned fee schedule mid to late July.

3. **Processing**

The new ASC reimbursement system may have fee schedule amounts of zero for codes which are allowable in the ASC, but are included in the fees associated with surgical procedures. Unlike other AHCCCS fee schedules if the fee for a procedure is $0.00 for the claim date of service the allowed amount for that procedure should be $0.00. The new reimbursement system will also follow Facility Outpatient Fee Schedule (OPFS) Correct Coding Initiatives (CCI).

Although our initial considerations also included moving Freestanding ASC billing from the CMS1500/837P Form Type to the UB04/837I Form Type, the final decision was to not make a change at this time to ensure consistency with Medicare (which changed to the CMS1500/837P Form Type on 1/1/2008).

We believe the new payment system will promote a better alignment of procedures and their payments and will open many appropriate codes for ASC utilization and allow for more business to be contracted to Freestanding ASC's.

AHCCCS has discussed this fee schedule with representative ASC providers and will continue to consult with them as issues arise. Please contact us if you have any questions about this.

There were about a dozen codes that were effective in 2007 that simply changed to new codes as of January 1, 2008. Those were changed in our system. Recently, we found several other codes that changed on January first that were not changed in our system. The updated list of ASC procedure codes and rates can be found on the AHCCCS website: www.azahcccs.gov/RatesCodes/Default.aspx

## NCPDP v5.1 File Construction

The vast majority of the examples in NCPDP Implementation Guide show the AM01 (Patient) segment before the AM04 (Insurance) segment. However, files with the AM04 segment first followed by the AM01 segment ALWAYS work better because, according to the Guide, the AM04 Insurance segment is always a required segment for billing transmissions while the AM01 Patient segment is an optional segment. Many NCPDP v5.1 translators defined their maps to expect the Insurance segment to precede the Patient segment. Consequently, for processing NCPDP v5.1 files through the AHCCCS translator, all reversals (B2) files should be constructed with the AM04 first, followed by AM01, and then AM07 (Claims) segment. [Files with the AM01 segment prior to the AM04 segment will only work if the last field on the AM04 segment is space filled to the maximum size of the field.] For ease of file construction and to obtain the best overall results, all files (B1 - billing, B2 - reversals, and B3- rebills) segments should be built in the following order: AM04, AM01, AM07, followed by the remaining segments. If you have questions regarding v5.1 file construction, please contact your technical assistant

## Submitting Denied Encounters

Prior to the implementation of the AHCCCS validator, plans were able to submit denied encounters separately from paid encounters. When our validator was implemented, denied encounters that contained at least one invalid code received a validator error and was not passed to the mainframe. [Invalid codes include but are not limited to: HCPCS, place of service, diagnosis, zip code, revenue code, transaction qualifiers, and claim adjustment reason codes. Essentially any data field that is populated with a code value may have invalid codes based on date of service (for medical code sets) or date of transaction (for non-medical code sets).] AHCCCS is working on a solution to this issue and believes a work-around is in the final stages.

Please follow thes interim guidelines. Plans are able to submit denied encounters by separating denied encounters into the following groups: (A) denied encounters with valid codes. For denied encounters with valid codes (Group A), the files must have the input mode of '6' in NM109 (per current companion document) use 'AHCCCS DENIAL' in the GS03, and add the extension of .deny to the file name. If all of the codes are valid, the file will pass TI and be moved to the mainframe as a denied file; and (B) denied encounters with at least one invalid code. The process for submitting denied encounters with invalid codes (Group B), is not yet complete. Therefore Group B denials can not yet be accepted by AHCCCS. As soon as the process for Group B denials has been finalized and tested, you will be notified.

Recall that previously we stated that only administrative denials were to be submitted to AHCCCS. Following is a draft list of generic administrative denial reasons grouped into denial categories. Recall also that only enrollment and eligibility edits would cause a denied encounter to pend. Plans are liable for correcting denied pends for enrollment and eligibility errors,which are sanctionable as an aged pend. It is recommended that plans do not submit enrollment and eligibility denials.

Administrative Denials for Encounter Collection

| Denial Category | Reason |
|---|---|
| | |
| **Medical Necessity/Review** | Denied per medical review |
| | No documentation to support medical necessity |
| | Documentation does not support medical necessity |
| | Documentation does not support services/charges |
| | |
| **COB** | EOB required |
| | EOB does not match claim |
| | Member has other insurance that must be billed first |
| | |
| **Billing** | Denied for bundled services |
| | CCI denial |
| | Untimely submission from claim receipt to date(s) of service |
| | Procedure included in base code |
| | |
| **Additional Information** | Requested documentation not received |
| | |
| **Prior Authorization** | Prior authorization not on file |
| | |
| **ESRD** | Service included in composite rate |
| | Service not related to ESRD condition |
| | EPO denied due to hematocrit level or not on claim |
| | Documentation needed to support services |
| | EPO Dose adjustment orders needed |
| | Date(s) of service/number of dialysis treatments not matched |

## State Medicaid Agencies on Medicare DMEPOS Cross-Over Claims

Starting in July 2008, the amount Medicare pays for certain medical equipment and supplies will be determined by competitive bids submitted by suppliers. The program will help save beneficiaries money; ensure that they can get quality medical equipment, supplies and services; and help limit fraud and abuse in the Medicare program. It is important that beneficiaries in affected areas understand how this program impacts the way they will receive these equipment and supplies.

It is important that dual-eligible beneficiaries follow the Medicare DMEPOS competitive bidding rules. Coverage of durable medical equipment under Medicare is an available third party liability resource and therefore, Medicaid programs have an affirmative obligation to cost avoid any claims. In other words, Medicaid cannot assume responsibility as primary payer for an item or service that would have been covered by Medicare had the individual gone to a covered supplier. Medicaid programs may pay as a secondary payer (e.g. assistance with co-pays) for claims that have been properly processed under these rules.

In most instances, the following remark codes on claims will help State Medicaid Agencies identify claims that have been processed under the National Competitive Bidding for DMEPOS rules. Please note remark code M115, which identifies when Medicare denied payment because the beneficiary did not utilize a contract supplier. If a State Medicaid Agency receives a cross-over claim with remark code M115, the State is not responsible for any payment on that claim.

Remark Codes Related to DMEPOS Competitive Bidding Program:

M112: Reimbursement for this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.

M113: Our records indicate that this patient began using this item/service prior to the current contract period for DMEPOS Competitive Bidding Program.

M114: This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding these projects, contact your local contractor.

M115: This item is denied when provided to this patient by a non-contract or non-demonstration supplier.

Note that remark code M113 will appear on grandfathered claims. (A grandfathered supplier is a non-contract supplier that elects to continue to provide certain rented DME or oxygen and oxygen equipment at the time a competitive bidding program begins in a competitive bidding area.)

However, please also note that if a claim is denied for a reason other than competitive bidding (such as medical necessity), one of the above remark codes may not appear. Therefore, the lack of one of those messages on a remittance advice does not necessarily mean that the claim would not have been subject to competitive bidding.

Another way to identify competitive bidding claims would be for the states to look at the zip code of the beneficiary's permanent residence and determine if that zip code falls into a competitive bidding area. Information on which zip codes are included in the program, as well as the suppliers who won a contract to supply particular items, can be found on our website at: http://www.cms.hhs.gov/DMEPOSCompetitiveBid

For more information on the DMEPOS competitive bidding program, you may access a general fact sheet on the program at: http://www.cms.hhs.gov/apps/media/press/factsheet.asp?

## Performance Measure Category of Service Reminder

According to the Performance Measures Advisory Group (an advisory body to the CPT Editorial Panel), performance measurement codes are intended to facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures and that have an evidence base as contributing to quality patient care.

Due to the inclusion of CPT Category II and other performance measure procedures in select HEDIS measurements, in January 2005 AHCCCS implemented a 'Non Pay Category 2 Codes' or '10' coverage code for HCPCS assigned to 'Performance Measures' or PM category of service. This structure allows plans to report performance codes for inclusion in HEDIS and other AHCCCS plan performance measurements.

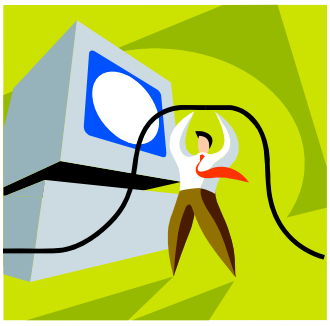
For additional information regarding performance measurement coding please refer to the CPT and/or HCPCS coding rules and guidelines. If you have questions regarding reporting these procedures to AHCCCS, please contact your encounter technical assistant.

## Not Otherwise Specified Codes

The reporting of 'Not Otherwise Specified' (NOS) codes should be limited. When an alternative HCPCS Level II or a CPT code better describes the service being reported NOS codes are not used. NOS codes should be used only if a more specific code is unavailable. For example, the reporting of L1499 (Spinal Orthosis, not otherwise specified) code should be limited because the spinal orthosis section of the HCPCS codes is robust and there should be an existing code for almost all spinal orthoses. If the reporting of NOS codes is above a reasonable limit, it is an opportunity to determine why the reporting of NOS codes is above expectations and/or offer provider education when a more specific code is available.

## Level 1 Trauma Center

On **Monday, July 21, 2008 at 8 A.M.** Phoenix Children's Hospital opened Arizona's only freestanding, Level 1 Trauma Center exclusively for Pediatric patients. An updated Outpatient Fee Schedule (OPFS) Facility Peer Groups listing reflecting this change will be posted to the AHCCCS website.



"Men have become the tools of their tools." -- Henry David Thoreau

## Bypass Select Edits (when Medicare is Primary)

AHCCCS has placed logic into production that will bypass select edits when Medicare has paid as primary, and plans are liable for coinsurance and/or deductible. This change applies to both 837P (professional - 1500) and 837I (institutional - UB) services. The encounter must show Medicare Approved/Allowed and Paid amounts greater than $0.00 The edits that are bypassed are displayed on the mainframe transaction table RF799. Effective October 1, 2008 data from RF799 table will also be included in the fourth reference file on the AHCCCS FTP server (REFER04). The current list of edits bypassed are listed below. Note that the Begin Date is 07/01/2005 and the End Date is 99/99/9999.

| Code | Description | Code | Description |
|---|---|---|---|
| D020 | Prim Diag Not Covered By AHCCCS On DOS | V030 | Revenue Code Not Covered |
| D035 | Recipient's Age > Prim DX Allow Max Age | V031 | Revenue Code To Bill Type Not On File |
| D040 | Recipient's Age < Prim DX Allow Max Age | V032 | Revenue Code Not Valid For Bill Type |
| I040 | Member Age Less Than ICD9 Proc 1 Min | V036 | HCPC Required For Revenue Code |
| I045 | Member Age Exceeds ICD9 Proc 1 Max | V037 | HCPC Not Appropriate For This Rev Code |
| S350 | Procedure Not Covered By AHCCCS On DOS | V125 | Accoms Can't Be Billed By O/P Or Clinic |
| S365 | Recipient's Age < Minimum For Procedure | V205 | Tot Ancill Noncovered = Tot Ancill Billd |
| S370 | Recipient's Age > Maximum For Procedure | V398 | Procedure Code Must Be Valid HCPCS Format XNNNN |
| S375 | Recipient's Sex Is Invalid For Procedure | V400 | Procedure Code Not On File |
| S385 | Service Units Exceed Maximum Allowed | V401 | Procedure Is In Pended Record Status |
| S417 | Service Billed Included In Facility Rate | V402 | Proc Code Missing Or Not On File For DOS |
| U200 | Revenue Code Is Invalid | V403 | Procedure Not Available On DOS |
| U205 | Days/Units Is Invalid | V406 | Procedure Is Medicare Only |
| U207 | Units Reqd For OP Enc With DOS > | V407 | Procedures Cannot Be Concurrently Billed |
| U600 | Detail Service Begin Date Is Invalid | V410 | Recipient's Age < Minimum For Procedure |
| U605 | Detail Service End Date Is Invalid | V411 | Recipient's Age > Maximum For Procedure |
| U610 | Dtl Srv End Date Prior Dtl Srv Beg Date | V412 | Recipient's Sex Is Invalid For Procedure |
| U615 | Hdr Srv Dates Must Encompass Dtl Srv | V445 | Procedure Modifier Invalid For Procedure |
| V010 | Revenue Code Not On File | V535 | Procedure Modifier Invalid For Procedure |
| V020 | Revenue Code Not On File For DOS | V540 | Inconsistency Between Modifier 1 & 2 |

## Code Updates & Changes

CPT Codes 93797 (Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)) and 93798 (Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)) has had the following changes:

- Coverage code is now 01 (Covered Service/Code Available) effective July 1, 2005
- Place of Service (POS) 49 (Independent Clinic) has an effective begin date of July 1, 2005
- Place of Service (POS) 20 (Urgent Care Facility) has been end dated effective January 1, 2003
- Effective for dates of service on or after June 2, 2008 the HCPCS code 77053 (Mammary ductogram or galactogram, single duct, radiological supervision and interpretation) has eliminated the gender requirements.
- Effective with dates of service on or after January 1, 2006 the HCPCS code J8540 (Dexamethasone, oral, 0.25 mg) has the following changes:
    - Coverage code of 01 (Covered service/code available)
    - Added to revenue code 0250
    - Procedure daily maximum of 32

## Provider Type Updates

- Effective for dates of service on or after January 1, 2008 the following codes can be reported by Provider Type 08 (physician) and 31 (DO-Physician Osteopath):
    - Q9965 (Low osmolar contrast material, 100-199 mg/ml iodine concentration)
    - Q9966 (Low osmolar contrast material, 200-299 mg/ml iodine concentration)
    - Q9967 (Low osmolar contrast material, 300-399 mg/ml iodine concentration)
- Effective for dates of service on or after January 1, 2008 the CPT code 95937 (Neuromuscular junction testing (repetitive stimulation )) can be reported by Provider Type 10 (Podiatrist).
- Effective for dates of service on or after January 1, 2007 the CPT code 24670 (Closed treatment of ulnar fracture, proximal end (olecranon process); without manipulation) can be reported by Provider Type 18 (Physicians Assistant).
- Effective for dates of service on or after January 1, 2007 the following CPT code 36870 (Thrombectomy, percutaneous, arteriovenous fistula autogenous or non autogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)), can be reported by Provider Type 31 (DO-Physician Osteopath).

## Category of Service (COS)

- Effective for dates of service on or after June 18, 2008 the HCPCS codes listed below are now associated with COS 01 (Medicine):
  - J0220 (Injection, aglucosidase alfa, 10 mg)
  - J0400 (Injection, aripiprazole, intramuscular, 0.25 mg)
  - J1300 (Injection, eculizumab, 10 mg)
  - J7321 (Hyaluronan or derivative, hyalgan or supartz, for intra-articular injection, per dose)
  - J7322 (Hyaluronan or derivative, synvisc, for intra-articular injection, per dose)

- The HCPCS code G0372 (Physician service required to establish and document the need for a power mobility device) has been added to COS 01 (Medicine) with an effective date of January 1, 2006.

- The following bill types have been added to PMMIS Reference screen RF769 (Medical Categories of Service) with an effective date of October 1, 2003 with COS 16 (Out-Patient Facility Fees):

  - 831 - Special facility ambulatory surgical admit thru discharge
  - 832 - Special facility ambulatory surgical interim 1st claim
  - 833 - Special facility ambulatory surgical interim con't claim
  - 834 - Special facility ambulatory surgical interim last claim
  - 835 - Special facility ambulatory surgical late chg(s) only claim
  - 836 - Special facility ambulatory surgical adj prior claim
  - 837 - Special facility ambulatory surgical replace of prior claim
  - 838 - Special facility ambulatory surgical void/cancel prior claim

- COS 30 (Home health nurse service) has been added to the following codes on PMMIS screen RF769 (Medical Categories of Service):

  - 99601 (Home infusion/specialty drug administration, per visit (up to 2 hours)); with an effective date of October 1, 2003.

  - 99602 (Home infusion/specialty drug administration, per visit (up to 2 hours)); each additional hour (list separately in addition to code for primary procedure) with an effective date of January 1, 2004.

## Place of Service (POS)

- Effective with dates of service on or after August 1, 2007 the HCPCS code 93926 (Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study) can be reported with POS 31 (Skilled Nursing Facility) and 32 (Nursing Facility).

- Effective with dates of service on or January 1, 2008 the HCPCS code 27767 (Closed treatment of posterior malleolus fracture; without manipulation) and 27768 (Closed treatment of posterior malleolus fracture; with manipulation) can be reported with POS 22 (Outpatient Hospital).

- Effective with dates of service on or after November 1, 2007 the HCPCS code L5010 can be reported with POS 12 (Home).

## Modifier(s)

The modifier QW (CLIA waived test) has been added to the PMMIS screen RF122 (Valid Procedure Modifiers) and W (CLIA waived) to RF113 (Procedure Code Indicators And Values) to the following codes with their effective dates:

| Code | Description | Effective Date |
|---|---|---|
| 82330 | Calcium; Ionized | 09/21/2007 |
| 82374 | Carbon Dioxide Bicarbonate | 09/21/2007 |
| 82435 | Chloride; Blood | 09/21/2007 |
| 84132 | Potassium; Serum | 09/21/2007 |
| 84295 | Sodium; Serum | 09/21/2007 |
| 84550 | Uric Acid; Blood | 03/14/2007 |

## Effective date(s)

The effective date for HCPCS codes S9490 through S9542 and S9325 through S9377 has been changed to October 1, 2003. To clarify, it is the effective date on the category of service for the code ranges that is effective 10/01/03, not the effective date of the code itself.).

## Age Limit

- Effective for dates of service on or after June 9, 2008 the HCPCS code 33961 (Prolonged extracorporeal circulation for cardiopulmonary insufficiency; each additional 24 hours (list separately in addition to code for primary procedure)) has no minimum age.
- The maximum age limit has been removed from the following HCPCS codes:
    - L0112 (Cranial cervical orthosis, congenital torticollis type, with or without soft interface material, adjustable range of motion joint, custom fabricated
    - L0120 (Cervical, flexible, non-adjustable (foam collar))
    - L0130 (Cervical, flexible, thermoplastic collar, molded to patient)
    - L0140 (Cervical, semi-rigid, adjustable (plastic collar)
    - L0150 (Cervical, semi-rigid, adjustable molded chin cup (plastic collar with mandibular/occipital piece)
    - L0160 (Cervical, semi-rigid, wire frame occipital/mandibular support)
    - L0170 (Cervical, collar, molded to patient model)
    - L0174 (Cervical, collar, semi-rigid, thermoplastic foam, two piece with thoracic extension)

- The minimum age has been removed from the following codes:
    - 332.1 (Secondary Parkinsonism)
    - 56441 (Lysis of labial adhesions).
    - J1190 (Injection, Dexrazoxane Hydrochloride, per 250 mg)
    - J1650 (Injection, enoxaparin sodium, 10 Mg)
    - K0195 (Elevating leg rests, pair (for use with capped rental wheelchair base)
    - L1499 (Spinal Orthosis, not otherwise specified)

‘Age is not a handicap. Age is nothing but a number. It is how you use it.”
Ethel Payne

## Edits

The following edits have been updated for form types I/P, O/P & LTC from "Y" pend to "N" off.

U251 - I/P or Home Hospice Rev Code Require 81X or 82X Bill Types
U261 - I/P or Home Hospice Rev Code Require 81X or 82X Bill Types

**Note: Edit status values are: 'N' for off; 'S' for soft; and three values of 'Y', 'H', and 'P' for hard. Only hard errors result in pended encounters.**

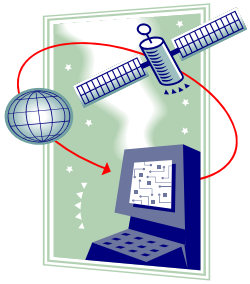
## P281 (Service Provider Not Enrolled on Date of Service) Reminder

For Service Provider Not Enrolled on Date of Service (P281) encounter pend error, the AHCCCS Provider Registration Unit can only change provider enrollment records by provider request. Without a change to the provider enrollment records that includes the service dates, encounters pending for this error cannot be accepted. If you have questions regarding the resolution of this pend error, please contact your encounter technical assistant.

## P330 (Provider Not Eligible for the Category of Service)

The actual rendering provider must be identified as the rendering provider on encounters. Group billing providers may also be identified but may not be submitted as rendering providers. Based on a review of P330 (provider not eligible for the category of service) pended encounter errors and feedback from plans, many P330 errors are due to group billing provider IDs incorrectly submitted as the rendering (service) provider. Group billing providers are identified in our provider files as group billers, e.g., provider type '01'. In order to easily distinguish group billing provider ID errors from other P330 errors AHCCCS is developing a mainframe adjudication edit to deny (reject) encounters when the group billing provider has been submitted instead of the rendering provider. Meanwhile, AHCCCS has built an on-demand adhoc to systematically identify and move these group biller P330 pend errors to a denial status. The denials will appear on 277U (status code 585) and 277U supplemental files as Denied by AHCCCS. In addition, each encounter will have a message stating the 'System Denied for Invalid Service/Rendering Provider'.

The correction of the group biller issues will remain as before; that is, when plans have corrected their encounters to reflect the actual rendering provider, replacement encounters must be submitted. If you have questions regarding the adhoc or the new edit, please contact your encounter technical assistant.



"The real problem is not whether machines think, but whether men do."

B.F. Skinner